

Referral to Rehabilitation Services

Consumer Information

Name: _____

Address: _____

Phone: _____

SSN: _____

DOB: _____

Gender: _____

County: _____

KAECSSES #: _____

Referral to RS

EES Case Manager: _____ Date of Referral: _____

Phone: _____ Email: _____

Applicant for the following:

- _____ TANF
- _____ Food Assistance
- _____ Medical
- _____ Child Care
- _____ SSI
- _____ SSDI

Recipient of the following:

- _____ TANF\$ _____
- _____ Food Assistance\$ _____
- _____ Medical
- _____ Child Care
- _____ SSI \$ _____
- _____ SSDI \$ _____

Status with EES:

- _____ Exempt
- _____ Mandatory
- _____ Voluntary

TANF Months used: _____

Describe the basis of the consumer's incapacity/disability and attach copies of any available medical, psychological or psychiatric reports. (Such as: CAP2, TABE, CDC/Vocational Assessment, SASSI, Self-Sufficiency Agreement, LD Information, Medical Providers, Psychological Evaluation, Initial Assessment Information, EES Screening Tool, Definitive Medical Report.) _____

Describe the consumer's interest in work or their feelings about work: _____

Consumer has been notified of the Referral: _____

Case Manager Signature: _____ **Date:** _____

cc: case file